VERMONT

HUMIRA® (adalimumab) - Prior Authorization and Patient Enrollment Form

Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name	First Name	Middle Initial
Date of Birth	Sex M ☐ F ☐	Medicaid ID #
Allergies: ☐ NKA or _____		
Street Address	City	
State	County	Zip Code
Home Phone	Cell Phone	
Parent/Guardian	Day Telephone	Night Telephone
Emergency Contact	Relationship	Telephone

2 PRESCRIBER INFORMATION

Prescriber's Name	NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name
Street Address	City	
State	County	Zip Code
Contact Person at Office	Prescriber Specialty	

Fax Completed Form to:

Fax Number: 866-364-2673

Phone Number: 800-327-1392

3 Office of Vermont Health Access
HUMIRA® (adalimumab)
PRIOR AUTHORIZATION REQUEST

Patient Diagnosis:

☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Juvenile Idiopathic Arthritis

☐ Ankylosing Spondylitis ☐ Plaque Psoriasis ☐ Crohn's Disease

If requesting prescriber is not a Rheumatologist, Dermatologist or Gastroenterologist, has one of these specialties been consulted on this case? ☐ **Yes** ☐ **No**

Specialist name: _____ Specialist Type: _____

List previous medications/therapies tried and failed for this condition: (include oral, injectable, topical, phototherapy etc.)

Therapy (and dates)	Reason for discontinuation

Prescriber Additional Comments:

4 PRESCRIPTION

Dosage Form and Quantity:

☐ Humira 40 mg/0.8 ml prefilled syringe Dispense Quantity: 2

or

☐ Humira PEN 40 mg/0.8 ml Dispense Quantity: 2

or

☐ Humira 40 mg/0.8 ml (Crohn's Starter kit-6) Dispense Quantity: 6 (1 kit)

or

☐ Humira PED 20 mg/0.4 ml prefilled syringe Dispense Quantity: 2

Sig: Dose/Route/Frequency:_____

Refill X:_____

Deliver product to: ☐ Patient's home ☐ MD office ☐ Clinic

Prescriber's Signature: _____ **Date:** _____

Last Updated 01/2009